

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029136

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 179

FILED AUG 7 1963

1. PLACE OF DEATH

a. COUNTY **LIVINGSTON**

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN **CHILLICOTHE**

Length of stay in 1b  
**10 DAYS**

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION **CITY HOSPITAL**

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **MISSOURI** COUNTY **LINN**

c. CITY  
OR  
TOWN **MEADVILLE**

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
**NO STREET ADDRESS**

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

**OLZY**

**JACKSON**

4. DATE  
OF  
DEATH

Month

Day

Year

**AUGUST**

**2,**

**1963**

5. SEX  
**MALE**

6. COLOR OR RACE  
**WHITE**

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
**11/17/1888**

9. AGE (last birthday)  
**75**

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**MILLER**

10b. KIND OF BUSINESS OR INDUSTRY  
**FLOUR MILL**

11. BIRTHPLACE (City and state or country)  
**ATCHISON, KANSAS**

12. CITIZEN OF WHAT COUNTRY  
**U.S.A.**

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

**DAVID JACKSON**

**BETSY ALICE CASTOR**

**LYDIA BELLE TROWBRIDGE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of  
**NO**

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

**MR. KENNETH JACKSON: CHILLICOTHE, MO.**

18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cerebral Hemorrhage**

INTERVAL BETWEEN  
ONSET AND DEATH  
**10 days**

DUE TO (b)

**Coronary Artery Disease**

DUE TO (c)

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

PART III. If deceased was female was  
there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURY Hour - Month, Day, Year  
a.m.  
p.m.

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **Aug 2** to **Aug 2** and last saw him alive on **Aug 2 1963**  
Death occurred at **5:30** P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
**BURIAL**

23b. DATE  
**8-4-63**

23c. NAME OF CEMETERY OR CREMATORY  
**WHEELING CEMETERY**

23d. LOCATION (City, town, or county)  
**WHEELING, MISSOURI**

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

**NORMAN FUNERAL HOME: CHILLICOTHE, MO. Aug. 4, 1963**

**Annalee Taylor**

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300

Rev. 4/59

10595

20580

3

4 0

5 2

6

7 1

8 2

9 331X

10

11

12 1-0

13 1-0

Permit not obtained:  
Date handed to Dr. Aug. 2, 1963  
Date rec'd from Dr. Aug. 5, 1963  
Date duly signed Aug. 5, 1963

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elton Norman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MISSOURI

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

DR. VANDIVER